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EDITORIAL

Management of Psychomotor (Temporal Lobe) Seizures

THE TERM "psychomotor epilepsy" was introduced in 1937 to designate a heterogenous group of seizures which did not conform to the classical descriptions of grand mal, focal or petit mal seizures. This has proved useful in emphasizing to the physician that the term "petit mal" should be reserved only for a characteristic disorder which develops in childhood or adolescence (onset rare, if ever, after the age of 20), with highly specific clinical features. Petit mal attacks are characterized by transient clouding of consciousness, an absence, lasting usually 5 to 30 seconds, with or without minor movements of the head or extremities (myoclonic jerks), following which the patient is alert and continues his usual activity. Occasionally loss of of postural tone may occur, and the youngster may drop to the floor in an akinetic petit mal attack. Often the child is unaware of having an attack and it may be dismissed by parents as momentary daydreaming or inattentiveness. The delineation of psychomotor attacks from petit mal has important implications with regard to the etiology of the seizure, the correlation with focal brain pathology, the need for diagnostic completeness, and the choice of therapy. Whereas petit mal seizures have not been associated with any focal pathology in the brain and pathophysiologically are considered to originate probably in deep central structures in the region of the thalamus, psychomotor seizures are a special form of focal seizure originating in either temporal lobe. Hence the term "Temporal Lobe Seizure" is widely used as a synonymous term. Recently, the term "limbic lobe" epilepsy has been used to also indicate that the disorder involves structures apart from the temporal lobe, although the limbic system has important projections to that lobe. (The limbic system is that phylogenetically old portion of the brain that serves as an anatomical and physiological basis for the emotions.)

The clinical features of temporal lobe epilepsy have been well-summarized by Walter in this issue of CALIFORNIA MEDICINE. These may be, on occasion, bizarre to the point of being considered hysterical or psychotic symptoms. The episodes last longer than petit mal attacks and are usually followed by post-seizure amnesia. One may note purposeful motor activity and behavior that is incongruous for the immediate situation. Movements noted may include lip smacking, fumbling with clothes or even disrobing. In addition to such automatisms, perceptual disorders, illusions, and "forced thinking" are common. Clinical patterns are highly variable but generally stereotyped in a given patient. Diagnosis is dependent upon the history obtained from the patient and of equal importance are the observations of family or friend to describe the behavior during the attack. The